

VI

BOOK REVIEWS

PRIMARY SYPHILIS IN THE FEMALE.* By T. Anwyl Davies, M.D., B.S., M.R.C.P.

By writing this admirable monograph, Dr. Anwyl Davies has made a valuable contribution to the literature of syphilis. He has shown therein that, contrary to the view expressed in the majority of text-books, the primary lesion of female syphilis is sited most frequently upon the cervix. The opinion as to the rarity of cervical chancre is enshrined in Fournier's "*Traité de Syphilis*," and upon his authority it has been most solemnly repeated from book to book. It is only too likely that, despite the evidence in the monograph under review, the error will be perpetuated for many years to come. Fournier records 249 cases of female chancre and finds only 5·2 per cent. on the cervix. Dr. Davies analyses the sites of 584 chancres occurring on the female genitals and finds that no less than 44 per cent. were located in that position.

That this latter finding is bound to be the correct one is quite evident if one pauses for a moment to consider the sexual act and the anatomical relationships of the male and female generative organs involved. From every aspect it would seem that the implantation of the virus of syphilis upon the female external genitalia must be the exception and not the rule. Everything conspires to make the vagina, the cervix, and the cervical canal the regions in which inoculation is most likely to take place. But these sites are not so easily inspected, either by the patient or by the physician.

Another point with respect to primary female syphilis to which the reviewer has already drawn attention is that it is only very rarely that a man with a penile chancre indulges in sexual intercourse. The vast majority of women who acquire syphilis are infected, not from a penile lesion, but from infective spermatic fluid. It has been shown that the testes of every male syphilitic in the post-primary stages of the disease show the presence of parasites. In countries where there is licensed and controlled prostitution—which is, of course, an utterly futile procedure from every standpoint—the periodical inspections by medical officers, and the care exercised by the brothel inmates themselves, seems in no great degree, if any, to reduce the rate of syphilitic infection among these women. The professional prostitute is taught to exercise every care that her temporary partner is not venereally infected. Their clients may not actually realise it, but the women really subject them, under the guise of amorous dalliance, to what is essentially a meticulous clinical examination as to the presence or absence of urethritis or chancre. On the discovery of either, intercourse would be refused. Apart from that altogether, it is the rule after a presumably healthy connection, for the woman to douche or to

* "*Primary Syphilis in the Female*," by T. Anwyl Davies, M.D. (Lond.), Director of the Whitechapel (L.C.C.) Clinic; late M.O. in Charge, and late S.M.O. of the Venereal Department at St. Thomas's Hospital, S.E. 1. Pp. 111, with seventeen colour plates and eight illustrations in the text. Oxford University Press, Humphrey Milford, London, 1931. Price 12s, 6d. (?)

BRITISH JOURNAL OF VENEREAL DISEASES

take other prophylactic measures. And yet, despite all the care exercised, perhaps the majority of these women acquire syphilis or gonorrhœa or both, and only very rarely is venereal infection diagnosed in the very early stages in spite of weekly examinations which in some places involves the use of a speculum. The only explanation would appear to be that inoculation is by infective material from the male urethra being deposited upon the cervix or into the cervical canal. This applies both to syphilis and to gonorrhœa.

It is therefore no matter for surprise to find that when the question of female primary genital syphilis is systematically and most competently investigated, as has been done by Dr. Anwyl Davies, nearly 50 per cent. of chancres are cervical.

In Dr. Davies' series, the labia majora account for 31·33 per cent. of chancres, and thus apparently this is the second most common site. Such chancres the author divides into erosive, ulcerative, and papular types. In considering such lesions one sometimes has grave doubts as to whether one is really looking at a primary chancre or at a secondary manifestation. To differentiate clinically may be well-nigh impossible, and, of course, histologically the two conditions are practically identical. *Treponema pallidum* may be recovered from either. The reviewer has repeatedly encountered clinical chancres on the labia from the site of which treponemata could be demonstrated and which were seldom accompanied by inguinal adenitis. When the incubation period was gone into, these were found to be secondary lesions. The reviewer is inclined to the opinion—which is not shared by Dr. Davies—that there is invariably an adenitis present in the nearest anatomically associated lymphatic glands to the chancre. Where there is an alleged vulvar chancre and no adenitis, the probability is that although the condition is syphilitic it is really secondary in nature. In Dr. Davies' series of 158 lesions of the labia majora diagnosed as primary chancres, inguinal lymphadenitis was completely absent in 60 per cent. There is more than a possibility then, that in these 95 cases, the real primary chancre was situated in the cervical canal which would make that the second most frequent site for inoculation. In trying to differentiate between a genital labial chancre and a secondary lesion in the same area, not much help is to be obtained from the serology as far as the Wassermann test is concerned, for—as Dr. Davies points out—it is not uncommon to find that the Wassermann is negative in a woman suffering from undoubted and florid secondary syphilis. In this respect the Kahn procedure is to be preferred. There is a serious fault in connection with the Table showing the incidence of primary syphilitic chancres of the cervix on p. 45 to which one would direct attention so that it may be remedied in future editions. There is a great discrepancy between this table and those on pp. 8 and 10. According to that on p. 10, the percentage of primary cervical chancres found by Dr. Davies was 44, whereas on p. 45 the percentage is given as 6·49. In the latter table the percentage is calculated on the total number of all cases of syphilis examined—from primary syphilis to general paralysis of the insane—totalling 3,972 in all. In the table on p. 10, on the other hand, the calculation is made upon the 584 cases of actual chancre seen, which is the correct method. The table on p. 45 is quite valueless and meaningless in another respect in that the percentages of the different elements composing it are not all calculated alike. For example, Dr. Davies' percentage of 6·49 is

BOOK REVIEWS

reckoned on total syphilis cases of all kinds, whereas Fournier's percentage of 5·2 is calculated upon the total number of chancres seen, *i.e.*, 249, as is shown on p. 8. Dr. Davies' figure in this table should therefore be amended to read, "44 per cent."

There is another point in the chapter on the incidence of primary syphilis which is rather unfortunate; the author includes as cases of "primary" syphilis, patients who actually had secondary symptoms. In this chapter and elsewhere he really uses the term "primary syphilis" simply to denote patients in whom the site of the chancre was identifiable. In the table on p. 2, which gives an analysis of 3,972 cases of female syphilis in all stages, he states that there were 14·55 per cent. of primary cases. Of these, however, 66, or 1·6 per cent., were extragenital infections. Leaving these out of account, there are 512 cases shown as primary syphilis, or 13·88 per cent. But 254 of these had secondary symptoms, and so therefore should be classified as such, which gives the actual percentage of patients presenting themselves in the primary phase of genital syphilis, as 6·49. This is a remarkably low figure, and one would like to think that it really represented the true state of affairs with respect to the incidence of fresh infections. That it represents only a fraction is only too evident from the experience that the records of any treatment centre for any period of twelve months will show that roughly some 70 per cent. of female patients present themselves for the first time suffering from, according to the Ministry of Health classification, (1) secondary syphilis, (2) syphilis latent in the first year of infection, and (3) all later stages. Dr. Davies' analysis shows—including the extragenital cases—that while 8·15 per cent. were in the primary phase, 88·28 per cent. were affected with secondary, tertiary, or latent syphilis. Again leaving the tertiary and latent cases on one side, since they may have had inadequate treatment previously for their secondary syphilis, we may assume that the remaining 30 per cent. came for treatment in the first instance on account of the early cutaneous symptoms. In the reviewer's clinic, taking the year 1930 as an average year, 8·1 per cent. of female patients were suffering from primary syphilis, while 30·6 per cent. were diagnosed as being in the secondary phase of the disease. Now this 30·6 per cent. must have been primary syphilitics some twelve or less months previously, but did not appear for treatment because the condition was unrecognised. This was no doubt due, as Dr. Davies emphasises, to the cervical situation of the chancre. It therefore seems reasonable to submit that the true annual incidence of primary syphilis cases attending any treatment centre *were diagnosis invariably possible in that stage in women*, would be somewhere in the region of 38·7 per cent. It would thus closely approximate the figure for male primary chancre.

In discussing chancres of the cervix and pregnancy, Dr. Davies states on p. 66 that a "study of the medical literature concerning syphilis and pregnancy brings to prominence . . . that writers are almost unanimous in declaring that syphilis assumes a much severer aspect in pregnant women. . . ." Surely it has been shown and is very generally recognised that the very reverse is the case. So well established is the clinical fact that pregnancy reduces the virulence of syphilis that it has been said that were it not for the liability of transmitting the disease to the offspring, pregnancy is a therapeutic measure

BRITISH JOURNAL OF VENEREAL DISEASES

of high value. Brown and Pearce have shown that pregnancy in inoculated rabbits has a markedly restraining influence in the development of the disease. Moore has also pointed out that while in both sexes the nervous system is invaded with equal frequency in the early stages, the development of neurosyphilis is very rare in women who have become pregnant since they were infected.

The sentence quoted from Dr. Davies' book does not represent his personal opinion, because on the following page he states: "My experience is that though severe cases may occur, they are the exception, and that in the majority of pregnant women the symptoms and signs of a general systemic infection are lessened and not so marked as in the average non-gravid female." The two sentences are mutually antagonistic, and certainly the reviewer's reading of the medical literature does not show that writers generally state that the disease is more severe during pregnancy.

The book is an ornament to British syphilology. It is one of deep interest, and it must surely take its place among the classics on the subject. Sometime in the future the natural history of syphilis must be written—a history wherein syphilis will be regarded from the biological and not so exclusively from the pathological angle—and when that comes about, this monograph by Dr. Davies will provide much of the material. The author has dared to question hallowed authority. He has weighed it up so far as female primary syphilis is concerned and has found it gravely wanting. The greatest drag upon the wheels of syphilology has undoubtedly been too great a reverence for alleged authority, and Dr. Davies is to be congratulated in having killed the myth of the rarity of the cervical chancre.

The whole subject of female syphilis is of tremendous importance. It is in that sex that the disease must really be studied and as it exists in its natural form. Only through a proper comprehension of female syphilis can the road be blazed to a thoroughly scientific therapy such as we do not at present possess. When it becomes realised that the *Treponema pallidum* is a protozoon, that the natural host with whom it lives in symbiotic amity is the human female, that the differentiation between she and the male is one of lipoid metabolism, that the lipoid-richness of the woman between puberty and the menopause is the cause of her high degree of resistance to the disease, and that every aspect and phase and variety of syphilis can only be explained in terms of lipoids, then there will emerge certain things which will point in a therapeutic direction whereby the cure of the disease and the prevention of visceral complications such as neurosyphilis will be brought about with certainty by a more rational utilisation of biochemical factors than at present.

A very special word of praise must be written for the extraordinarily high artistic merit of the colour photographs which illustrate this monograph. They are a triumph both for Dr. Davies who took and developed them and for the artist who reproduced them.

So highly does one think of this book that one hopes for a second and enlarged edition in the near future in which the author will amend some of the tabular and statistical information. It were a pity if, in a work of such high merit, there should be allowed to exist a single flaw.

E. T. B.